FILED
JAN 5 1994
OFFICE OF THE CLERK

No. 93-655

In the Supreme Court of the United States

OCTOBER TERM, 1993

EVANSTON HOSPITAL, PETITIONER

v.

ROBERT V. HAUCK, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

BRIEF FOR THE FEDERAL RESPONDENT IN OPPOSITION

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QUESTION PRESENTED

Whether, under Medicaid, a provider hospital is precluded from seeking additional reimbursement for services rendered to a Medicaid beneficiary after the provider has accepted payment in full from the government for the services

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1-7) is reported at 1 F.3d 540. The opinion of the district court (Pet. App. 9-14) is unreported.

JURISDICTION

The judgment of the court of appeals (Pet. App. 8) was entered on July 30, 1993. The petition for a writ of certiorari was filed on October 25, 1993. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

Petitioner claims that the Secretary of Health and Human Services and the Director of the Illinois Department of Public

Aid (IDPA) improperly preclude it from seeking additional reimbursement for services rendered to respondent Robert V. Hauck, a Medicaid beneficiary, even though petitioner previously accepted payment in full from Medicaid for the services.

1. Medicaid is a federal-state program established under Title XIX of the Social Security Act, 42 U.S.C. 1396 *et seq.*, to provide medical assistance to, *inter alia*, eligible aged, blind and disabled individuals and to families with dependent children. Under Medicaid, each State submits to the Secretary a plan for program administration, which must comply with broad federal statutory guidelines. See generally *Schweiker* v. *Gray Panthers*, 453 U.S. 34, 36-37 (1981). Upon the Secretary's approval of the plan, the State becomes eligible for federal financial participation (FFP) in payments to providers of medical assistance. 42 U.S.C. 1396b(a). The Secretary furnishes the FFP directly to the State, and she may withhold or limit FFP if she determines that the State is not complying with federal requirements. 42 U.S.C. 1396c(2). Illinois participates in Medicaid under an approved state plan.

Under the Medicaid statute, a State's plan must have a provision requiring "reasonable measures to ascertain the legal liability of third parties (including health insurers) to pay for care and services available under the plan." 42 U.S.C. 1396a(a)(25)(A). By regulation, the Secretary has required that, if third-party liability is not established at the time a provider's claim is filed with the State, the State must pay the claim. 42 C.F.R. 433.139(c). If third-party liability is subsequently established and the amount of reimbursement the State can expect to recover exceeds the costs of recovery, the State is then required to "seek reimbursement for such assistance to the extent of * * * legal liability" of the third party. 42 U.S.C. 1396a(a)(25)(B), 42 C.F.R. 433.139(d) and (f). On the other hand, if "probable" third-party liability is

established at the time the provider submits its claim, the State is required to reject the claim and return it to the provider for a determination of the amount of third-party liability. 42 C.F.R. 433.139(b). After that determination is made, the State must then pay to the provider any allowable amount in excess of the third party's payment. 42 C.F.R. 433.139(b)(2).[1]

The Medicaid statute also provides that (except for any applicable deductible, coinsurance or copayment amounts) the provider of a service "may not seek to collect from the individual (or any financially responsible relative or representative of that individual) payment of an amount for that service." 42 U.S.C. 1396a(a)(25)(C); 42 C.F.R. 447.15. Hence, if a provider submits a claim to the State for a particular service, it must accept the amount paid by the State (plus any deductible, coinsurance or copayment amounts required to be paid by the individual) as payment in full.

2. Respondent Hauck sustained injuries as a result of an electrical accident and was treated by petitioner in 1985 and 1986. Hauck could not pay his bill, which totalled $270,760.24, but he was eligible for Medicaid. Pet. App. 1, 9. Petitioner submitted a request for payment under Medicaid to respondent IDPA, which reimbursed petitioner in the amount of $113,424. *Id.* at 1, 10.

Some time following petitioner's receipt of the Medicaid payment, petitioner served a lien on a personal injury lawsuit that respondent Corboy & Demetrio had filed on Hauck's behalf. Pet. App. 10. In December, 1991, Hauck settled his lawsuit for $9.6 million. *Id.* at 2, 4, 10. Petitioner sought to

[1] To assist in the collection process, the Medicaid statute requires the State to include, as a condition of an individual's eligibility for medical assistance, a requirement that the recipient of care assign to the State all rights to payment for medical care from any third party. 42 U.S.C. 1396a(a)(45), 1396k(a).

return to respondent IDPA the $113,424 it had received under Medicaid so that it could pursue Hauck and Corboy & Demetrio for the full amount of its charges for Hauck's treatment. *Id.* at 10. IDPA refused to accept petitioner's repayment, and instead sought its own reimbursement directly from Hauck. *Ibid.*[2] Petitioner thereafter filed the instant action, seeking a declaratory judgment that it could repay Medicaid and seek full payment for its services directly from Hauck and Corboy & Demetrio. *Ibid.*

3. a. The district court dismissed the complaint. Pet. App. 9-14. The court noted that the Illinois Medicaid plan limits participation to providers that accept, as payment in full, the amounts paid by IDPA, and held that the Illinois plan "exactly complies with the federal mandate" under Medicaid. *Id.* at 11 (citing 42 C.F.R. 447.15 and Ill. Ann. Stat. ch. 305, para. 11-13 (Smith-Hurd 1993)). The court also rejected petitioner's argument that the requirements of the Illinois plan conflict with the federal Medicare secondary payer provisions, and found unpersuasive petitioner's argument that Medicaid's role as payer "of last resort" requires IDPA "to seek or accept repayment from the health-care provider" in these circumstances. Pet. App. 12-13.

b. The court of appeals affirmed. Pet. App. 1-8. The court noted that petitioner voluntarily accepted payment under Medicaid in lieu of assuming the risk of "possibly full payment or possibly no payment at all." *Id.* at 2-3. The court found that Congress intended "that state Medicaid agencies, not hospitals or doctors, seek reimbursement from third par-

[2] Petitioner's appendix omits from the district court's opinion certain language indicating that IDPA sought reimbursement from Hauck for the Medicaid services rendered. See Pet. App. 10 (after the word "reimbursement" on lines 13-14, the opinion should read "for the amount it paid to Hauck. Plaintiff filed suit * * *"). The Secretary understands that IDPA has obtained its reimbursement.

ties," *id.* at 5, for services previously paid for by the state agencies, and that Medicaid explicitly prohibits the provider from seeking additional reimbursement under those circumstances. The court concluded that the recourse against Hauck for the cost of his care consequently "belongs to the government, not to Evanston Hospital." *Id.* at 7. Although the court acknowledged that Hauck would receive a "windfall" equal to the value of the medical care he received but for which the government did not pay, it recognized that "Congress decided it should be the recipient of medical care, not the hospital," who should benefit under the circumstances. *Ibid.*

ARGUMENT

The decision of the court of appeals is correct and does not conflict with any decision of this Court or of any other court of appeals. Further review is therefore not warranted.

1. Congress has granted the Secretary "exceptionally broad authority" to implement the Medicaid statute. *Schweiker* v. *Gray Panthers*, 453 U.S. at 43. The Secretary's reasonable interpretation of the provisions of the Medicaid statute at issue in this case lie amply within her authority. Under the statute, Congress has required that state plans include a provision requiring "reasonable measures to ascertain the legal liability of third parties (including health insurers) to pay for care and services available under the plan." 42 U.S.C. 1396a(a)(25)(A). Congress has also required that if "legal liability is found to exist after medical assistance has been made available," a state plan must include a provision requiring the State to seek reimbursement from the third party where the reasonable recovery exceeds anticipated costs. 42 U.S.C. 1396a(a)(25)(B). Finally, Congress has mandated that a provider furnishing medical assistance under Medicaid "not

seek to collect from the individual (or any financially responsible relative or representative of that individual) payment of an amount for that service," except for any applicable deductible, copayment or coinsurance amounts. 42 U.S.C. 1396a(a)(25)(C).

In accordance with these statutory directives, the Secretary promulgated regulations that treat the issue of third-party liability differently depending on the likelihood of that liability at the time a provider files a Medicaid claim. See 42 C.F.R. 433.139. As detailed above, when "probable" third-party liability is established at the time a claim is filed, the regulations require the State to reject the claim and return it to the provider for a determination of the amount of probable liability before the State can disburse a Medicaid payment. 42 C.F.R. 433.139(b). To that extent, and contrary to petitioner's suggestions (Pet. 5), Medicaid is a payer of last resort under the regulations. On the other hand, when "probable" third-party liability is not established at the time a claim is submitted, the regulations require the State to pay the claim. 42 C.F.R. 433.139(c). In the event that third-party liability is established at some later point, the State, not the provider, must pursue any recovery. 42 C.F.R. 433.139(d) and (f); 42 U.S.C. 1396a(a)(25)(C); 42 C.F.R. 447.15. Medicaid is again a payer of last resort, but it is the State, not the provider, that seeks reimbursement to recover the Medicaid payment.

It is uncontested in this case that "probable" third-party liability was not established at the time petitioner submitted its claim for payment from Medicaid. As the court below explained, prior to 1991, "Hauck's $9.6 million award was merely a gleam in the eye of a personal injury lawyer." Pet. App. 4.[3] Accordingly, under the Secretary's regulations, IDPA

[3] Hauck did eventually recover a substantial amount in his tort suit. However, nothing in either the statute or the regulations authorizes

was required to pay petitioner's Medicaid claim for its treatment of Hauck at the time the claim was submitted. 42 C.F.R. 433.139(c). The court below properly rejected petitioner's efforts to undo that arrangement.

2. Petitioner points to other portions of the statute, as well as to certain regulatory amendments and the Secretary's responses to comments in the rulemaking process. For example, petitioner cites 42 U.S.C. 1396b(*o*), which penalizes States that permit private insurers to limit their coverage based on an individual's eligibility for or receipt of Medicaid. See Pet. 5-6.[4] Because no third-party payer sought to avoid payment on the ground that Hauck's eligibility for and receipt of Medicaid limited the third-party's liability, Section 1396(*o*) does not apply.

Petitioner also quotes responses by the Secretary to comments on 42 C.F.R. 447.20, which was promulgated in 1990. See Pet. 7 (quoting 55 Fed. Reg. 1423, 1428-1433 (1990)); see generally 55 Fed. Reg. 1423 (1990) (implementing portions of Section 9503 of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat.

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petitioner to insist on reimbursing Medicaid subsequent to that award, in order to pursue Hauck. To the contrary, Congress prohibited such a result. The Medicaid statute explicitly requires that the State pursue any viable claims if legal liability is found to exist "after medical assistance has been made available," and prohibits petitioner from collecting from the individual for services rendered. 42 U.S.C. 1396a(a)(25)(B) and (C).

[4] 42 U.S.C. 1396b(*o*) states, in pertinent part:

> Notwithstanding the preceding provisions of this section, no payment shall be made to a State * * * for expenditures for medical assistance provided for an individual under its State plan approved under this subchapter to the extent that a private insurer * * * would have been obligated to provide such assistance but for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or is provided medical assistance under the plan.

205).[5] Section 447.20 applies only in cases of "established liability of the third-party or parties for the [Medicaid] service." 42 C.F.R. 447.20(a). At the time petitioner submitted its claim for Hauck's treatment under Medicaid, third-party liability was not established. Section 447.20 is therefore inapplicable.

Further, Section 447.20(a) permits providers to collect deductibles, coinsurance or copayments from the individual Medicaid beneficiary or his or her representative only in limited circumstances, and otherwise prohibits such collections. See 42 C.F.R. 433.139(b). In responding to a comment expressing concern that the latter prohibition would restrict receipt by providers of "amounts from [other] resources available to the recipient [such as third-party insurance]," the Secretary assured providers that the purpose of Section 447.20 "is to protect the Medicaid recipient from being charged for a service in excess of the amounts allowed under the State plan after considering the third-party's liability," and that it did not restrict providers "from receiving amounts from third party resources available to the recipient (or his or her legal representative)." 55 Fed. Reg. 1428 (1990) (quoted at Pet. 7). This comment was directed at the circumstances under which Section 447.20 applies—that is, where third-party liability is established at the time a Medicaid claim is submitted. Contrary to petitioner's argument, it does not provide general authorization for a Medicaid provider to seek recovery from a third party after the provider has already accepted payment in full under Medicaid. See 42 C.F.R. 447.15.

[5] To the extent petitioner relies upon regulatory amendments and responses to comments issued by the Secretary in 1990, those changes do not apply retroactively to govern its reimbursement for services rendered in 1985 and 1986. See *Bowen* v. *Georgetown Univ. Hosp.*, 488 U.S. 204 (1988).

Petitioner next relies on the Secretary's response to a comment on Section 433.139(b)(3), which was also promulgated in 1990. Pet. 9-10 (citing 55 Fed. Reg. 1426, 1433 (1990)). That Section implements 42 U.S.C. 1396a(a)(25)(F) and creates special procedures for circumstances in which a third party's "liability is derived from an absent parent whose obligation to pay support is being enforced by the State title IV-D agency." 42 C.F.R. 433.139(b)(3).[6] The language quoted by petitioner requires a provider to reimburse Medicaid (either through repayment or as an offset against future Medicaid payments, at the State's option) if the provider receives payment from a liable Title IV-D third party after Medicaid has paid. See 55 Fed. Reg. 1426 (1990). This case does not involve Title IV-D, and there is no indication that the reimbursement option referred to by the Secretary in that comment was intended to apply outside of the context of Title IV-D claims. *Ibid.*

3. Petitioner also argues that the agency interpretation applied here has improperly "extinguish[ed]" its "lien right" under the Illinois Hospital Lien Act. Pet. 11 (citing Ill. Ann. Stat. ch. 770, para. 35-1 (Smith-Hurd 1993)). As the court of appeals explained, however, under Illinois law, when a provider accepts a Medicaid payment, its "[a]cceptance * * * shall bar [the provider] from obtaining, or attempting to obtain, additional payment [for goods or services covered] from the recipient or any other person." Pet. App. 2 (citing Ill. Ann. Stat. ch. 305, para. 11-13 (Smith-Hurd 1993)). In this case, petitioner voluntarily accepted payment under Medicaid as payment "in full" and promised not to pursue Hauck, in exchange for avoiding "possibly no payment at all." Pet.

[6] Title IV, Pt. D, of the Social Security Act, 42 U.S.C. 651 *et seq.*, establishes programs to enforce support obligations owed by absent parents to their children.

App. 2-3. Any lien rights petitioner might have had under state law were lost as a result of its own actions, not those of the Secretary.

4. Petitioner finally contends that the courts below "misunderst[ood] the reality of provider treatment of patients and reimbursement in the current health care environment." Pet. 11; see Pet. 11-14. Essentially, petitioner argues that the delays inherent in the tort system create an economic incentive for a provider to pursue immediate payment by Medicaid and to forgo the "potential[ ] wait[ ] in excess of ten years for payment * * * from a liability insurer." Pet. 12. Petitioner suggests that permitting it to reimburse Medicaid at a later date and then pursue payment from the beneficiary or his or her liability insurer will "assur[e] that liable third parties pay claims * * * which the Medicaid system erroneously paid" and will preclude "windfall[s]" for Medicaid beneficiaries. Pet. 12-13. As the court below noted, however, petitioner "bought certainty" in opting for payment by Medicaid rather than by a liability insurer. Pet. App. 3. Congress and the Secretary have determined that any right of pursuit for reimbursement in these circumstances belongs to the State, not the provider, and that any windfall should redound to the benefit of the "recipient of medical care," for whom the Medicaid program was devised, rather than provider hospitals. *Id.* at 7.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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JANUARY 1994

☆ U.S. GOVERNMENT PRINTING OFFICE: 1993—301-157/86083